| AME OF PROVIDER OR SUPPL | j | A. BUILO | TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01 | MB NO. 0938- (X3) DATE SURVE COMPLETED |
|--|--|---------------|--|--|
| | 445228 | B. WING | <u> </u> | j |
| IFE CARE CENTER OF G | | | STREET ADDRESS, CITY, STATE, ZIP CODE 725 CRUM STREET | 02/27/201 |
| (X4) ID SUMMARY | TATEMENT OF DEFICIENCIES | <u>,</u> | GREENEVILLE, TN 37743 | |
| | ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | |
| health licensure a care facilities on 2 survey. Life Care found to be in sub requirements for pure Medicare/Medicail Life safety from fir Protection Associated 2012 edition. NFPA 101 Egress Doors Doors in a required equipped with a latture of a tool or key using one of the foliarrangements: CLINICAL NEEDS LOCKING Where special lock clinical security need only one locking deed each door and proving removal of occlocks; keying of all times; or other suito the staff at all time 18.2.2.5.1, 18.2.2. SPECIAL NEEDS LOCKING Where special locking afety needs of the polinical or Security Leging met. In additionelectrical locks that fellectrical locks th | ey was conducted by the state of trent of Health, Division of nd regulation office of health /27/17. During this life safety Center Greeneville was not stantial compliance with the articipation in at 42 CFR Subpart 483,70(a), e, and the related National Firetion (NFPA) standard 101 - Doors means of egress shall not be ch or a lock that requires the from the egress side unless lowing special locking OR SECURITY THREAT Ing arrangements for the dis of the patient are used, sice shall be permitted on sions shall be made for the supants by: remote control of locks or keys carried by staff at the reliable means available as. 2.6, 19.2.2.2.5.1, 19.2.2.2.6 OCKING ARRANGEMENTS g arrangements for the attent are used, all of the | K222 | Life Care Center of Greeneville is committed to upholding the highest standard of care for its residents. This includes substantial compliance with all applicable standards and regulatory requirements. The facility respectfully works in cooperation with the State of Tennessee Department of Health towa the best interest of those who require the services we provide. While this Plan of Correction is not to be considered an admission of validity of any findings, it is submitted in good faith as a required response to the surve conducted February 27-April 1, 2017. Plan of Correction is the facility's allegation of substantial compliance with Federal and State requirements. What corrective action will be accomplished by the deficient practice: 1) All facility maintenance personnel were immediately in-serviced on NFPA 101 Life Safety Code Standards on 2/27/17 by the Execut Director. a) There is one lock device with our releasing motion to open the exit do from dictary to rear of the building. The Maintenance Director removed the chain lock and dead bolt lock on 2/27/17. | rd he y This tive e |

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients, (See instructions.) Except for nursing homes, the findings attated above are disclosable 90 days is following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

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| STATEMEN | IT OF DEGICIENALES | (X1) PROVIDER/SUPPLIER/CLIA | | | | FOR OMB No | MAPPROVEI <u>0. 0938</u> -039 |
|-------------------|--------------------------------|---|--|------------|---|--------------------|----------------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | (X2) MU | LTIPI | re coustkocttok | | Y. VOO-UJY ATE SURVEY |
| | | | A BUILE | DING | 01 - MAIN BUILDING 01 | , co | MPLETED |
| NAME OF | PROVIDER OR SUPPLIER | 445228 | B. WING | ; | | | |
| | | | | Š | TREET ADDRESS, CITY, STATE, ZIP CODE | 0; | 2/27/2017 |
| IFE CA | RE CENTER OF GREE | ENEVILLE | - 1 | 77 | 25 CRUM STREET | | |
| | | •• | | | REENEVILLE, TN 37743 | | |
| (X4) ID PREFIX | I LACO DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL | מו | | PROVIDER'S PLAN OF CORRECT | A., | _ |
| TAG | REGULATORY OR LS | C IDENTIFYING INFORMATION) | PREFIX | | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | 202 | COMPLETION DATE |
| K 222 | Continued From pag | TO 1 | | · | How you will identify other residents | handu 4 | |
| | Drotocted has sure | je i | K 2 | 22 ; | the potential to be affected by the same | naving | 1 |
| | protected by a super | vised automatic sprinkler | į | : | deficient practice and what corrective | <u>o</u> action | ļ |
| | Complete amake 4-4 | ed space is protected by a | 1 | į | will be taken: | actron | ĺ |
| i | complete smoke det | ection system (or is | | | 2) a) All facility residents and vi | citore | ! |
| | within the looked as- | at an attended location | ĺ | i | have the potential to be affect | v4 911012 | İ |
| i | within the tocked spa | ice); and both the sprinkler | | • | 100% audit completed by the | ou. | |
| ļ | and defection system | is are arranged to unlock the | | ! | Maintenance Director of all c | rit daam | 1 |
| , | doors upon activation | 1. | | 1 | to ensure all exits have only o | ctr anotz | <u> </u> |
| | 18.2.2.2.5.2, 19.2.2.2 | 4.5.2, TIA 12-4 | | | locking device and | iiC | į J |
| | DELAYED-EGRESS ARRANGEMENTS | FOCKING | | ĺ | no further areas of concern we | r h o | į į |
| ł | Approved listed data | | | | found on 2/27/17 | | <u> </u> |
| i | installed in accordant | yed-egress locking systems | | - ; 2 | What measures will be put into place of | r whor | |
| | Demitted on door on | ce with 7.2 1.6.1 shall be | | _] ≥ | ystemanc changes you will make to en | 101177 | i |
| j | Offinant hazard contr | semblies serving low and | | Į <u>Ę</u> | <u>Dat the deficient practice does not recu</u> | <u>بہ</u> آ | ľ |
| | throughout by an one | ents in buildings protected | | ¦ 3 | a) All facility maintenance ner | Soppel | j |
| ĺ | fire detection custom | roved, supervised automatic | | ļ | were immediately in-serviced | m l | ĺ |
| - { | automatic sprinkler sy | or an approved, supervised | | | NFPA 101 Life Safety Code | | j |
| | 18.2.2.2.4, 19.2.2.2.4 | ystem. | | | Standards on 2/27/17 by the Ex | ecutive | |
| [] | ACCESS-CONTROL | LED EGRESS LOCKING | | - { | Director. The Maintenance Di | rector | |
| l. | ARRANGEMENTS | CED EGRESS LOCKING | | - { | and/or the Maintenance Assista | nte | |
| 1. | Access-Controlled Fo | ress Door assemblies | | İ | will do audits to monitor comp | lance | [|
| i li | installed in accordance | e with 7.2.1.6.2 shall be | | | weekly for 4 weeks and month | v for 2 | |
| | permitted. | e with 7.2.1.0.2 shall be | | İ | months. | | |
| | 18.2.2.2.4, 19.2.2.2.4 | , | | ᆝ뵤 | low the corrective action will be monit | pred to |] |
| | ELEVATOR LOBBY F | XIT ACCESS LOCKING | | ं द्रा | isure the deficient practice will not rec | **** | |
| 1 * | AKKWINGEMEN12 | | | 1.0 | hat quality assurance program will be | <u>put</u> | Į. |
| (1 | Elevator lobby exit acc | ess door locking in | | ())) | to place: | | j |
| 6 | accordance with 7.2.1 | .6.3 shall he nermitted on | | (4) | vess of telanticitying Will | 1 | j |
| j N | Jour assemblies in pu | IIGINGS Drotected throughout | | l | present results of audits to the | - 1 | 1 |
| 1 6 | y an approved, suber | Vised automatic fire | | į | Performance Improvement | i | |
| - 14 | retection system and : | an approved supervised 15 | | | Committee. | 1 | ļ |
| , , | inthilisec sbulkiet SA | stem. | | 1 | b) The Performance Improvem | ent | |
| 1 | [8.2.2.2.4, 19.2. <u>2.2.4</u> | | | ļ | Committee Consisting of Execu | tive | Į |
| ון | his STANDARD is no | ot met as evidenced by: | | İ | Director, Director of Nursing, |] | 1 |
| 1 ' | pasen ou obset/900U | Bild interview the facility | | | Medical Director, Director of | | ! |
| 16 | auso to maintain exit d | 200fS. This deficiency | | i | Rehabilitation, Director of Heal | thi | i |
| ja | iffected one of nine sn | noke compartments. | | ŀ | Information, Dietary Manager, | [| 1 |
| - 1 | | | | | Director of Maintenance, Direct | Or of | |
| | he finding includes: | | | | Environmental Services, Director | r of | - 1 |
| CMS-2567 | (02-99) Previous Versions Obs | oleta Europe III. III. | | <u> </u> | Social Services, Business Office | | |
| | | olete Event ID: IXX321 | Fæ | cility i | D; TN3004 If continuer | On sheet | Page 2 of 5 |

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| A | ND PLAN | D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | | | J. 0938-039 TE SURVEY | |
|---------------------------------|-----------------------------|--|---|--|---|-----------------------|--------------------------|--|
| L | | 445228 | | | | | MPLETED | |
| NAME OF PROVIDER OR SUPPLIER | | B. WING_ | | ده ا | 2/27/2017 | | | |
| LIFE CARE CENTER OF GREENEVILLE | | | <u> </u> | | STREET ADDRESS, CITY, STATE, ZIP CODE 725 CRUM STREET GREENEVILLE, TN 37743 | | | |
| | (X4) ID PREFIX | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | | | | |
| | TAG | ^) | | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | COLLO DE LACADITATION | | |
| | K 222 Continued From page 2 | | K 22 | 2 Manager, Activities Director Staff Development Coordin | r, and | . | | |
| | | door from dietary to releasing motions to 4.6.12 & 7.2.1.5.10.2 | ector was present when the | | review the results. If it is de necessary by the committee, additional education may be provided, the process evaluated/revised, and/or the reviewed for 3 months or un compliance is achieved. | emed | | |
| | K 341 | 2/27/17. | fied and was acknowledged during the exit conference on | | | | | |
| - | , | accordance with NFF and NFPA 72, Nation provide effective warr building. In areas not detection is installed a unit. In new occupance at notification appliant and supervising station Fire alarm system wir paths are monitored fit 18.3.4.1, 19.3.4.1, 9.6 | installation installed with systems and d for the purpose in A 70, National Electric Code, al Fire Alarm Code to hing of fire in any part of the continuously occupied, at each fire alarm control by, detection is also installed be circuit power extenders, in transmitting equipment ing or other transmission or integrity. 9.6.1.8 | K 341 | for those residents found to have been by the deficient practice: 1) All facility maintenance personal were immediately in-serviced NFPA 101 Life Safety Code Standards on 2/27/17 by the Executive Director. a) Visible notification device winstalled in the dining room by Maintenance Director on 3/2/1 How you will identify offier residents he the potential to be affected by the same deficient practice and what corrective as will be taken: 2) a) All facility residents and visit have the potential to be affected by the Maintenance Director of all are | mnel on vas the 7. | 4/15/17 | |
| | 1 1 | pased on observation | and interview, the facility notification devices were | , | required to have visible notificate devices and revealed no further of concern 2/27/17. | tion areas | | |

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STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 445228 B. WING NAME OF PROVIDER OR SUPPLIER 02/27/2017 STREET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE CENTER OF GREENEVILLE 725 CRUM STREET GREENEVILLE, TN 37743 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX 10 PROVIDER'S PLAN OF CORRECTION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) What measures will be put into place or what K 341 Continued From page 3 systematic changes you will make to ensure K 341 that the deficient practice does not recur; Observation and interview with the maintenance a) All facility maintenance personnel were immediately in-serviced on director on 2/27/17 at 2:30 PM revealed the NFPA 101 Life Safety Code Standard dining room was not provided with a visible 2/27/17 by the Executive Director. notification device. NFPA 101, 19.7.6, 4.6.12 & The Maintenance Director, and/or the NFPA 72, 18.5.4 Maintenance Assistants will do audits The maintenance director was present when the to monitor compliance weekly for 4 deficiency was identified and was acknowledged weeks and monthly for 2 months. by the administrator during the exit conference on on 2/27/17, How the corrective action will be monitored to K 741 NFPA 101 Smoking Regulations ensure the deficient practice will not recur; SS≃D What quality assurance program will be put Smoking Regulations into place: Smoking regulations shall be adopted and shall include not less than the following provisions: 4) a) Director of Maintenance will (1) Smoking shall be prohibited in any room, present results of audits to the Performance Improvement ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored Committee. and in any other hazardous location, and such b) The Performance Improvement area shall be posted with signs that read NO Committee Consisting of Executive SMOKING or shall be posted with the Director, Director of Nursing, Medical Director, Director of international symbol for no smoking. Rehabilitation, Director of Health (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all Information, Dietary Manager, major entrances, secondary signs with language Director of Maintenance, Director of Environmental Services, Director of that prohibits smoking shall not be required. (3) Smoking by patients classified as not Social Services, Business Office Manager, Activities Director, and responsible shall be prohibited. Staff Development Coordinator will (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision, review the results. If it is deemed (5) Ashtrays of noncombustible material and safe necessary by the committee. additional education may be design shall be provided in all areas where provided, the process smoking is permitted. evaluated/revised, and/or the audits (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall reviewed for 3 months or until 100% be readily available to all areas where smoking is compliance is achieved.

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| STATEMEN | T OF SECTION | A INCUICATO SERVICES | | | | FORM | M APPROVE | |
|---------------|---|---|----------------|------------|--|---------------------------------------|----------------------------|--|
| AND PLAN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MD | TIP | LE CONSTRUCTION | <u> MB NC</u> |). 0938-039 | |
| | To made Hole | IDENTIFICATION NUMBER: | A BUILE | PING | 01 - MAIN BUILDING 01 | | TE SURVEY MPLETED | |
| NAME OF | PROVIDER OR SUPPLIER | 445228 | B. WING | | | ١. | | |
| | THO MUCK OK SUPPLIER | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 02 | /27/2017 | |
| LIFE CA | RE CENTER OF GREE | ENEVA 1 E | | 7 | 25 CRUM STREET | | | |
| | | PIAC AICE | i | | | | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | , — | _ | REENEVILLE, TN 37743 | | | |
| PRÉFIX TAG | ! LEACH DEFICIENCY | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP | VDE | (X5) COMPLETION DATE | |
| | | | | - | DEFICIENCY) | ··· | ; ! | |
| K 741 | Continued From pag | de 4 | | | What corrective action will be accomp | ished | ; | |
| | permitted. | y | K 7 | 41 | for those residents found to have been | ffected | 4/15/17 | |
| į | 18.7.4, 19.7.4 | | i I | : | by the deficient practice: | | j | |
| | 1 1411-1 1411-4 | i | | ' | All facility maintenance perso | nnet | i | |
| | This STANDARD is | took made on available of the | | į | were immediately in-serviced | UN . | 1 | |
| | Based on observation | not met as evidenced by: | | ļ | NFPA 101 Life Safety Code | OIL | | |
| ļ | failed to maintain do | on and interview, the facility | | : | Standards on 2/27/17 by the | | | |
| İ | tened to manifell de | signated smoking areas. | | - 1 | Executive Director. | İ | | |
| | The finding includes | _ | | į | a) A metal container with self | | | |
| ! | THE MICHAELES | - | | : | closing cover immediately place | | | |
| 1 | Observation and inte | , | | ; | the designated smoking area by | eu m | | |
| | director on 2/27/47 a | erview with the maintenance | | į | Maintenance Director on 2/27/ | une | ne | |
| 1 | emotion area was | t 9:30 AM revealed the | | | MADE DIRECTOR OF 2/2// | , , , , , , , , , , , , , , , , , , , | | |
| 1 | smoking area was not provided with a designated metal container with a self-closing lid into which ashtrays can be emptied as required. NFPA 101, | | | - | How you will identify other residents he | | | |
| ļ | | | | | the potential to be affected by the same | ying | | |
| İ | | | | - 13 | deficient practice and what corrective ac | | | |
| į | 19,7,4 (6) | 1 | | j, | will be taken; | <u> 1990</u> | | |
| | Th | | | | | i | | |
| | The maintenance din | ector was present when the | | - 1 | A THE PERSON NAMED IN TAXABLE PARTY OF THE P | tora | | |
| 1 ' | deliciency was idebiii | 190 and was acknowledged in | | i | have the potential to be affected | i. | i | |
| | nà miè aoimili2ft3f0t (| during the exit conference on | | | 100% audit completed by the | | | |
| 1 | 2/27/17. | | | ł | Maintenance Director to ensure | the | | |
| į | | j | | : | designated smoking area has a | netal 📗 | | |
| | | | | | container with self-closing cover | rand | | |
| - | | ĺ | | ; | revealed no further areas of con | cem | į | |
| i | | | | 1. | on 2/27/17. | j | | |
| i | | İ | | 3 | What measures will be put into place or | ybat | 1 | |
| | | | | 3 | vstematic changes you will make to ens | unce | i | |
| - 1 | | <u> </u> | | : <u>U</u> | hat the deficient practice does not recur: | - 1 | ľ | |
| i | | j | | د | All facility maintenance person | ıel i | ſ | |
| 1 | | ļ | | ! | were immediately in-serviced or | ı | | |
| ļ | | } | | | NFPA 101 Life Safety Code | | ľ | |
| | |] | | į | Standards on 2/27/17 by the | - | ſ | |
| | | | | - | Executive Director. The | [| . 1 | |
| - | | ļ | | , | Maintenance Director, and/or th | ₽ | 1 | |
| ļ | | į | | i | Maintenance Assistants will do: | audits | [| |
| İ | | | | 1 | to monitor compliance weekly for | or 4 | f | |
| ļ | | | | | weeks and monthly for 2 months | i. | İ | |
| 1 | | • | | | - | ļ | j | |
| į | | j | | 1 | | |] | |
| | - | | | | | ļ | j | |
| CMS-2587 | (02-99) Previous Versions Obs | Diete Sand ID-Divare | | | | | | |

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| AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA | (XZ) MULTIPLE CONSTRUCTION | | | | OMB NO. 0938-039 | | |
|------------------------|---|---|----------------------------|----------------|--|-----------------------|----------------------------|--|--|
| | | IDENTIFICATION NUMBER: | A. BUIL | DING | 601 - MAIN BUILDING 01 | (X3) D/ | TE SURVEY | | |
| NAME OF | PROVIDER OR SUPPLIER | 445228 | B. WING | ; | | 1 | | | |
| LIFE CA (X4) 10 | ARE CENTER OF GRE | ENEVILLE | | 7 | STREET ADDRESS, CITY, STATE, ZIP CODE 725 CRUM STREET GREENEVILLE, TN 37743 | | <u>//27/2017</u> | | |
| PREFIX TAG | I CAGA DEFICIENC | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | 55 | (X5) COMPLETION OATE | | |
| - | permitted. 18.7.4, 19.7.4 This STANDARD is Based on observation and interestor on 2/27/17 is moking area was metal container with ashtrays can be emitted. The maintenance dideficiency was identification. | s not met as evidenced by: ion and interview, the facility esignated smoking areas. | K7 | } ¹ | How the corrective action will be monit ensure the deficient practice will not rec What quality assurance program will be into place: 4) a) Director of Maintenance will present results of audits to the Performance Improvement Committee. b) The Performance Improvement Committee Consisting of Execu Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Healt Information, Dietary Manager, Director of Maintenance, Director Social Services, Business Office Manager, Activities Director, and Staff Development Coordinator review the results. If it is decine necessary by the committee, additional education may be provided, the process evaluated/revised, and/or the aud reviewed for 3 months or until 16 compliance is achieved. | ent tive h or of r of | | | |